Title: Violence and under-reporting: learning disability nursing and the impact of environment, experience and banding

Abstract
Violence within the National Health Service (NHS) continues to constitute a significant issue, especially within mental health and learning disability services where incidence remain disproportionately high despite the context of zero tolerance. This paper reports further on the implications of a survey into the discrepancy between actual and reported incidents of violence in the learning disability division of one mental health NHS Trust. A whole-population survey of 411 learning disability nurses was conducted yielding a response rate of nearly 40%. There were distinct differences in the levels of violence reported within specific specialist services along with variation between these areas according to clinical environment, years of experience and nursing band. The study doesn't support previous findings whereby unqualified nurses experienced more incidents of violence than qualified nurses. The situation was less clear, complicated by the interrelationship between years of nursing experience, nursing band and clinical environment. The conclusions suggest that the increased emphasis on reducing violent incidents has been fairly successful with staff reporting adequate preparation for responding to specific incidents and being well supported by colleagues, managers and the organisation. The differences between specific clinical environments, however, constituted a worrying finding with implications for skill mix and staff education.

Key Words
Learning disability; violence; staff experience; workplace reporting; zero tolerance

Word count
4068

Aims and objectives
The paper explores the implications of a survey into the discrepancy between actual and reported incidents of violence, perpetrated by service users, within the learning disability division of one mental health NHS Trust. A whole-population survey of 411 learning disability nurses was conducted yielding a response rate of approximately 40%.

Background
Violence within the NHS continues to constitute a significant issue, especially within mental health and learning disability services where incidence remain disproportionately high despite the context of zero tolerance.

Conclusions
There were distinct differences in the levels of violence reported within specific specialist services along with variation between these areas according to clinical environment, years of experience and nursing band. The study doesn't support previous findings whereby unqualified nurses experienced more incidents of violence than qualified nurses. The situation was less clear, complicated by the interrelationship between years of nursing experience, nursing band and clinical environment. The conclusions suggest that the increased emphasis on reducing violent incidents has been fairly successful with staff reporting adequate preparation for responding to specific incidents and being well supported by colleagues, managers and the organisation. The differences between specific clinical

environments, however, constituted a worrying finding with implications for skill mix and staff education.

Relevance to clinical practice

The study raises questions about the relationship between the qualified nurse and the individual with a learning disability in the context of violence and according to specific circumstances of care delivery. The relationship is clearly not a simple one and this group of nurses understanding and expectations of tolerance requires further research; violence is clearly never acceptable but these nurses appear reluctant to condemn and attribute culpability.

Keywords

Learning disability; violence; staff experience; workplace reporting; zero tolerance

Introduction

Violence within healthcare settings has become increasingly unacceptable (NAO, 2003), particularly since the implementation of the *Zero Tolerance Zone Campaign* (NHS, 1999) initiated in response to the escalation in numbers of incidents from 65,000 annually (DoH, 1999) to 95,000. Nursing professional bodies, furthermore, had always emphasized the likelihood of this being a significant under-estimation (RCN, 1998; UKCC, 2002). The Counter Fraud and Security Management Service was established, in part, as a mechanism for collecting statistical data and addressing the issue of violence (CFSMS, 2006). The zero tolerance campaign served to focus efforts more emphatically across services, accepting the traumatising effects of violence and need for "support, guidance, supervision and counselling systems" to be in place (CoT, 2005: 1). A greater emphasis was placed on reporting to the police with a subsequent fifteen-fold increase in prosecutions (NHS Press Release, 2005). There were just over 60,000 physical assaults recorded for 2004/5, two thirds of which were in mental health and learning disability settings (CFSMS, 2006). These figures then reduced to around 55,000 during 2008/9, 39,000 of which were within mental health and learning disability services, where staff continued to report three times the level of other healthcare settings (NHS SMS, 2009). Violent incidents in psychiatric units have been recognized as higher than within other healthcare sectors (NICE, 2005), accounting for more than three-quarters of compulsory detentions (Alexander and Singh, 1999).

This paper investigates further analysis of the under-reporting of violence and aggression found within one learning disability NHS service. It raises questions about how the relationship between years of experience, nurse banding, incidents of violence and likelihood of reporting.

Literature Review

There is no clear consensus over the definition violence making it difficult to assess the extent of the problem (Needham et al., 2005). Breakwell (1997) emphasizes behaviour intended to do harm against someone else's will, whereas Ryan and Poster (1993: 38) emphasize 'physical contact (resulting) in feelings of personal threat'. The Health and Safety Executive (HSE, 1998) refer to abuse, threat or assault of people, which was subsequently adapted to 'in circumstances related to their work' as the basis of the zero tolerance campaign (DoH, 1999: 1). Other writers have differentiated between the targets of violence (i.e., others, self, property), whether physical or verbal (Morrison, 1993) and the seriousness and extent of the injuries, including whether a weapon has been used and treatment required (HSAC, 1987). There remains, regardless of how we define violence, both considerable likelihood of under-estimation (CFSMS, 2006) and considerable evidence of the risk posed to learning disability and mental health nurses (NHS SMS, 2009).

Research into those affected by violence indicates healthcare assistants as the most vulnerable (Vanderslott, 1998), with less experienced staff considered more likely to miss triggers, subtle behavioural changes and diminishing opportunity for early intervention or de-escalation (McKenzie et al., 2003). A Royal College of Nursing (RCN, 2002) staff survey established that 43% of respondents had experienced violence, only half of whom had reported it, and the predominant reason surrounded a lack of understanding as to what constituted a reportable incident. The implications suggest that the higher the band of staff, then the less the likelihood of experiencing workplace violence and aggression, and the greater the likelihood of knowing what to report and the processes involved. Turnbull (1994) suggests a hierarchy of reporting, with patient against patient violence considered most seriously, and incidents of aggression against staff frequently disregarded or considered

unintentional if the individual was physically unwell. Mental health issues, similarly, have been regarded, not only as contributory evidence for violence, but also as reasonable cause for not including in official statistics (McGregor, 2006). Mental health and learning disability settings, furthermore, have a greater degree of tolerance towards violence and aggression, a greater incidence, yet also a considerable underestimation (NAO, 2003).

One learning disability service study reported 81% of staff experiencing violence over a twelve-month period, (Kiely and Pankhurst 1998), whilst 87% of learning disability nurses encounter feelings of threat or actual physical assault at some point in their career (Reeves, 1994). The violence and aggression initiated by some people with a learning disability, however, is an issue fraught with difficulty, with little consensus as to the explanatory terms used. Disturbed (NIMHE, 2004), behavioural distress (Gates, Gear and Wray, 2000), problem (LaVigna and Willis, 1986), difficult (Olsson and Hwang, 2001) and disruptive (Cole, Usher and Cargo, 1993) are just some of the descriptive terms used directly in relation to this group. An examination, furthermore, of bullying within a forensic learning disability service identified verbal and physical aggression as the main problems, similar behaviours ascribed a different label according to the focus of the study (Sasse and Gough, 2005). Over recent decades the term challenging behaviour has gained in acceptance, used originally primarily in relation to those with a severe learning disability and significant communication difficulties (Emerson and Bromley, 1995). The term has become increasingly prevalent but has also served to confuse the relationship between learning disability and violence. It was first forwarded in the late 1980s, then revised slightly in the mid-90s, to “culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities”

(Emerson, 2001: 3). The change in approach towards the aggression and violence engaged in by some individuals with a learning disability infiltrated services quickly, suited the dominant rights-based service ethos and has proven hugely influential. The unintended consequence, though, has been the expansion of the term, away from the emphasis on those with a severe learning disability originally envisaged, toward a more expansive way of addressing a variety of behaviours. Challenging behaviour, in relation to learning disability, has been used to include knife carrying and threatening to stab others (Dunn and Bolton, 2004), and assaults and use of weapons more generally (Emerson et al., 2001), whilst Harris (1993), lists behaviours such as slapping, scratching, pinching and biting alongside using weapons and throttling.

Research Question

The research sought to identify any discrepancy between actual and reported incidents of violence within the learning disability services of one NHS Trust. Findings confirmed a discrepancy existed and the reasons for it tended to reflect the literature (Skellern & Lovell, 2008). This paper explores relations between nurse banding, years of service, experience of violence and likelihood of reporting.

Method

A whole population survey was conducted of 411 clinical nursing staff (bands 3 to 8 inclusive) working with people with a learning disability within one NHS Trust. The questionnaire was constructed with primarily forced-choice questions relating to experience of incidents of violence over the previous six month period. Departmental managers acted as facilitators in accessing the sample by helping to distribute and collect the questionnaires, though remaining unaware of those who had or had not responded. This facilitating role was

outlined in the letter of explanation in order to prevent bias or exertion of pressure. This letter provided additional participant information and a stamped addressed envelope was also included in the pack. The workplaces participating in the study comprised community teams (4), respite (4), residential (4), assessment & treatment (4) and medium secure service (1).

Ethical approval was successfully acquired from the University Faculty Research Ethics Sub-Committee, the Integrated Research Application System (IRAS, formerly the National Research Ethics System, NRES) and the host Trust. Details of support, which staff might access in the event of distress from recalling experiences of violence, were included on the questionnaire. Completed questionnaires were then returned to the researcher. This approach personalised the distribution whilst maintaining the confidentiality and anonymity of the participants. No identifying data was collected. Consent was implied through the right of non-response.

Sample

Respondents (n=164) comprised those currently working with people with a learning disability in qualified and unqualified capacities i.e. band 3 (76), band 4 (2), band 5 (22), band 6 (45), band 7 (15) and band 8 (4). Nurse banding was implemented following the 'Agenda for Change' initiative (DoH, 2004) whereby a national single pay system was implemented and nursing roles and responsibilities were reorganised to replace the previous nurse grading system. Bands 3 and 4 refer to unqualified nursing roles and bands 5, 6, 7 and 8 qualified positions with escalating managerial and leadership responsibilities.

The staffing composition of the organisation participating in this study was fairly representative of learning disability services nationally, albeit with considerable regional

variation. The increasing concern over ensuring learning disability nurses are employed according to their specialist expertise is reflected in the service skill mix, with social support within a residential setting less likely to warrant regular and sustained nursing input. Table 1 shows the overall staffing structure of the service and the differences between the nursing areas of provision. The simplest structure is within the medium secure service with five band 3 and six band 6, and the most complex relates to community nursing with staff employed at each band and a much greater proportion at seven and eight. Both respite and residential services employed a much higher proportion of staff at the lowest band and the highest concentration of band six staff were in low secure followed by assessment & treatment. The low numbers of band 4 nurses reflects the service composition with unqualified staff primarily being employed in the lower band (3).

Table 1: Nursing band and workplace (% of service in brackets)

Band	Community Team	Respite Care	Residential Home	Assessment and Treatment	Medium Secure
3	21(33.8%)	13(52%)	24(70.5%)	13(35.1%)	5(45.5%)
4	2(3.2%)	0	0	0	0
5	6(9.7%)	7(28%)	2 (5.9%)	7(19%)	0
6	16(25.8%)	3(12%)	5(14.7%)	15(40.5%)	6 (54.5%)
7	12(19.3%)	1(4%)	1(2.9%)	1(2.7%)	0
8	3(4.8%)	0	0	1(2.7%)	0

(Note: percentages in each column do not total 100% because a small number of respondents did not provide banding and/or workplace details.)

The length of experience of nursing staff within the different services requires further elaboration. Community teams included 43% at band 3 with <5 years experience (and 71.4% <10 years), and only 4.5% with >20 years. In contrast, only 12.5% of bands 5, 6 & 7 staff had <5 years (and 33.3% <10 years), while 47% had >20 years (rising to 75% of bands 7).

The respite service included 7.6% of band 3 with <5 years (46% <10 years) and 15.4% >20 (38.5% >15 years). Bands 5, 6 & 7 staff had 22.2% < 5 years and 44.4% >20 years.

Residential staff included 16.6% of band 3 staff with <5 years (33.3% <10 years) and 29.1% >20 years (54.1% >15 years). Bands 5, 6 & 7 had no staff with <5 years (14.2% <10) and 57.1% >20 years.

The experience of staff within assessment & treatment units included 23% of band 3 with <5 years (53.8% <10) and 15.3% >20 years (46.1% >15). 27.2% of bands 5, 6 & 7 had <5 years (54.5% <10) and 22.7% >20 years (31.8% >15 years).

The staffing structure in the medium secure service (i.e. only band 3 and 6) comprised 20% of band 3 with <5 (same for <10) and 60% >20 years. 33.3% of band 6 had <5 years (50% <10) and 16.6% >20 (50% >15).

Data analysis

The data was stored on computer within university premises and secured by password. It was tabulated and analysed with the assistance of the Statistical Package for the Social Sciences (SPSS). The experience and reporting patterns of violent incidents was the main focus, particularly how this was influenced by factors such as length of time in the service, clinical grade and current place of employment.

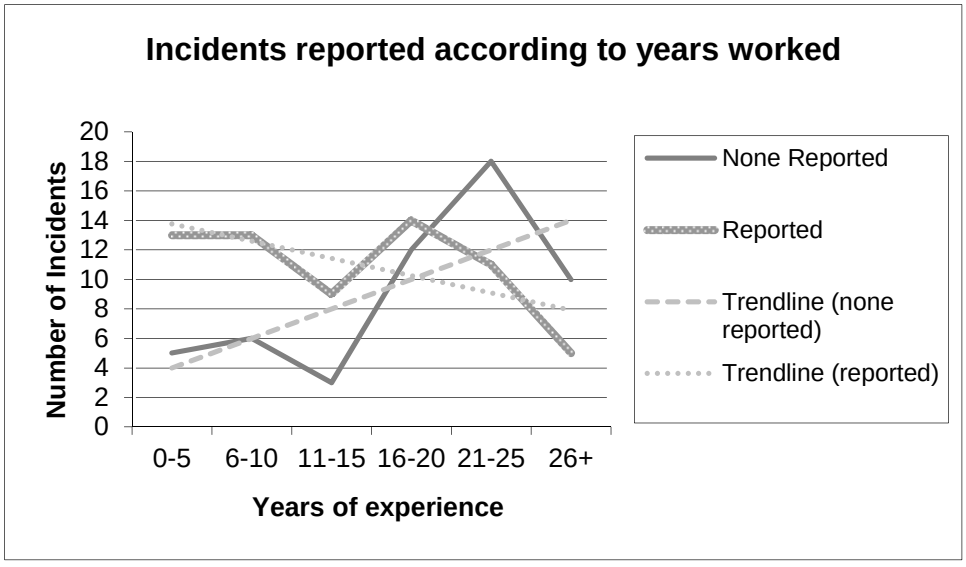
Results

A total of 411 questionnaires were distributed resulting in a response rate of approximately 40% (n=164). The results revealed 74.7% (n=123) of respondents having been subject to violence within the workplace. 18.2% (n=30) of respondents formally reported all incidents and 15.6% (n=26) reported none, whilst the others reported selectively. The main reason for

non-reporting was that the respondent considered the incident as ‘minor’ (42.9% for physical; 72.6% for verbal), followed by staff regarding a degree of violence as ‘part of the job’. Other reasons, in descending order, comprised ‘waste of time’, ‘lack of time’, ‘lack of support’ and ‘fear of repercussions’. Most nurses (88%) had received some training, primarily control and restraint (53%), but also Multi-Agency Public Protection Arrangements (MAPPA) (27%), breakaway techniques (22.6%), challenging behaviour (12.2%), de-escalation (3.9%) and vulnerable adults training (2.6%). Nearly two-thirds of respondents i.e. 63.6% did feel sufficiently prepared to work with service users who were likely to be verbally aggressive and/or physically violent.

Figure 1 indicates the overall experience of violence in relation to years worked in the service, with less evidence of reporting occurring as the years in the service increase, as the trend lines demonstrate.

Figure 1: Incidents reported according to years worked



Tables 2 and 3 indicate the number of incidents of violence experienced, firstly in relation to staff banding and then according to workplace.

Table 2: Band and Incidents experienced

Band	No incidents experienced	1 – 5 incidents	6 – 10 incidents	10+ incidents	Total (% of respondents)
3	38	21	11	6	76 (46.9%)
4	1	0	1	0	2 (1.2%)
5	5	6	7	4	22 (13.5%)
6	15	16	8	6	45 (27.7%)
7	3	9	1	2	15 (9.2%)
8	2	2	0	0	4 (2.5%)

14.6% of qualified (bands 5, 6 & 7) experienced >10 and 19.5% 6-10 incidents as opposed to 7.5% and 15.1% for unqualified (band 3). 49.3% of unqualified reported no violence and 28% of qualified reported none. Band 5 staff were the most afflicted single grade, 50% experiencing 6-10 and 18.1% >10 incidents.

Table 3: Workplace and incidents experienced

Workplace	No incidents experienced	1 – 5 incidents	6 – 10 incidents	10+ incidents
Community	33	22	2	4
Respite	10	13	1	1
Residential	14	9	7	4
A & T	2	11	14	10
Medium secure	6	3	2	0
Not provided	2	2	1	1

The different environments sustained varying levels of violence revealing that 33 (53.2%) community staff reported not having encountered a single violent incident, which compares worryingly with assessment & treatment where the number was only 2 nurses (5.4%). More than half medium secure staff encountered no violence with similar proportions from residential 14 (41.2%) and respite 10 (40%). These two services differed markedly at the other end of the scale, however, with residential having a third of staff (32.4%) reporting

more than 5 episodes compared with only 8% in respite. Community staff reported less than 10% over 5 incidents and low secure a little less than a fifth (18.2%), whereas assessment and treatment reported nearly two thirds (64.9%). Assessment & treatment, furthermore, had as many staff (i.e. 10) report more than 10 incidents as the other environments combined. Assessment & treatment, therefore, contained by far the highest level of violence, unsurprising in comparison with some environments though less so in relation to medium secure. In the residential service 14 staff (41.2%) reported not experiencing any violence, with 23 (67.6%) encountering <5 incidents, though this still means that 11 (32.4%) experienced >5.

The results of the survey, in summary, didn't support previous evidence of unqualified nurses experiencing the most violence, suggesting a more complex situation with the variation arising more from differences in clinical environment than staff banding. Similarly, years of experience was an important but complicated factor, sometimes acting as an indicator of increased violence but sometimes not.

Discussion

The perception of violent incidents as 'minor', a 'waste of time' or 'part of the job' suggested initially a degree of detachment or depersonalisation, with staff being, perhaps, somewhat inured to violence. They were, furthermore, more likely to be longer serving staff with considerable experience and a nursing qualification, which again accorded with the explanations of poor training or burnout. The results, however, didn't support previous reports of inadequate training (McKenzie et al., 2003) or mandatory training obligations not being fulfilled (Vere-Jones, 2006); effective training was clearly being provided (NAO, 2003), with some inconsistency but a general response of staff feeling adequately prepared to

respond to violent incidents. Nursing staff were clearly aware of their responsibilities (NMC, 2008) and familiar with systems of documentation (NICE, 2005). The issue of burnout, similarly, appears unsupported, the organisation providing strong backup with regard to counselling availability and there being little evidence of fear of repercussions, poor managerial support or general provision of policies and procedures. Explanations, therefore, for under-reporting of violence by qualified nurses needed to focus elsewhere.

Clinical environment

The marked variance in likelihood of being recipient of violence according to specific working environment is not hugely surprising, particularly that community nursing, residential and respite services witnessed far fewer incidents. Respite care witnessed the least violence, probably accounted for by the nature of health respite where the majority of service users present considerable health-related issues but less aggression. Further exploration into the severity of violence reported, however, might prove fruitful, since the nature of incidents experienced within community settings where immediate support is not guaranteed might render these situations more difficult. The surprise, though, relates to medium secure, which ostensibly contains those individuals with the greatest propensity for violence, detained through court action under mental health legislation. It might be the case that this environment with its balanced, yet fairly simple, skill mix has more severe incidents when they do occur but far fewer in total. The nature of the medium secure service with its emphasis on levels of security (i.e. physical, procedural and relational) may have influenced the relatively small number of incidents experienced. There is some evidence that staff working within medium security have greater self-efficacy than community staff and a lower fear of violence (Rose, Levenson & Howard, 2009). The service was also in a state of flux with an imminent negotiation in status from medium to low security, the implications of

which were not known to the staff. This change of status constituted part of wider service development within national secure learning disability services, and a further study might investigate whether there was a subsequent fluctuation in the level of violence.

Assessment and treatment units are more versatile environments, subject to a greater degree of volatility because of the critical circumstances frequently prevailing when an individual is in need of care. The use of civil detention under mental health legislation, the often complex and strained relations with family and the frequent changes to service users spending time in the units all make for an increased likelihood of violence and aggression. The staffing structure was a little more complex with an additional layer of band 5 staff, nearly double the number of qualified compared with unqualified. This service, nevertheless, did experience a far higher incidence of violence than other services, though it is more difficult to ascertain the nature of these incidents, whether sustained, perpetrated by a few individuals or evenly spread amongst service users. Hakeem and Fitzgerald (2002) point out that the conceptualization of violence as challenging behaviour might militate against people with learning disabilities in assessment and treatment units taking responsibility for their actions, and perhaps contribute to the increased levels of violence experienced.

Years of experience

The simplicity in the staffing structure of the medium secure unit might be related to the low level of violence experienced; this was an established team with little turnover, qualified and unqualified working together, a strong sense of identity and team cohesion. There was virtual parity between qualified staff, who were all employed at the higher band 6, and unqualified staffing. The service user group was generally more able and staff very clear about the particular strategy to be employed in the event of violence, with control and restraint

procedures constituting a last resort but with strong consistency amongst staff having undertaken the course. More than half the staff had experienced no incidents of violence, despite the relatively high potential when people are detained within conditions of medium security.

Community services (after residential) had the most staff reporting no incidents of violence and employed the most experienced qualified staff, followed by respite and residential services. The assessment and treatment service was more balanced with nearly a third of qualified having over 15 years experience but over a quarter having less than 5 years, there being much more fluidity of staffing turnover and also these units providing the starting point for many learning disability nurses as they commence their careers. The changeover of unqualified staff within this service appears also to be significant with nearly a quarter having less than 5 years experience. This combination of new, younger qualified nurses and healthcare assistants with relatively limited experience might contribute to the more pervasive violence within this service.

The findings of previous studies, concluding that less experienced staff encountered more incidents of violence (e.g. Vanderslott, 1998; McKenzie et al, 2003), are confirmed in the environments of community, respite and residential. These findings are not supported, however, in the medium secure service where there was equity between experience of violence, whilst in assessment and treatment the reverse applied and qualified staff encountered much greater levels of violence than unqualified.

Nursing Band

The general trend within the service was towards a well established workforce, which, with

the exception of assessment and treatment, provided a degree of stability. Qualified staff did experience a greater amount of violence than unqualified and were reluctant to report, though it was a little more complicated than this. The medium secure service decision to appoint qualified at a higher level was ostensibly successful since the level of violence was low and the level of staff turnover, both qualified and unqualified was low. Qualified learning disability nurses are increasingly having to demonstrate their expertise and providing a lead in responding to violence is important, particularly in defusing incidents and avoiding having to physically intervene. This may be an issue within the assessment & treatment service where there are issues, perhaps, around recruitment and retention, in both qualified and unqualified capacities. Community nursing has benefited in the locality from the advent of the specialist practice qualification over recent years, many community nurses benefiting from a prolonged period of education and time away from the clinical environment. Qualified nurses within assessment & treatment have had no such opportunity to expand their knowledge and clinical experience. It is possible that there might be an associated feeling of being secondary to the needs of community nurses and a lack of recognition of the skills and knowledge required in these settings. The exposure to a greater amount of violence might be a significant reason for a similar course combining practice and theory but focused at this group of acute service nurses.

Community nurses were exceptionally well established with nearly half having more than 20 years experience and, for band 7, this rose to three quarters; and the level of violence was relatively low with very few encountering regular violence. It was the band 5 and 6 staff, however, who bore the brunt of the violence, those at band 7 either being distanced by virtue of managerial position or working as community nurses. The relationship between qualified learning disability nurse and individual with a propensity for occasional violence appears

complicated. This experienced group of staff are less likely to report violence despite their considerable experience.

Conclusion

The zero tolerance campaign has contextualized NHS violence for more than a decade, with considerable effort to render unacceptable any sort of violence against staff. It seems, though, that the concept might rest uneasily with many of those working with people with a learning disability, who appear clearly aware of the need for reporting and the processes and procedures involved. An effective organisational strategy in the management of violence must clearly comprise a number of elements: comprehensive risk assessment; good time management; accurate record keeping; regular training in de-escalation and other approaches to violence; good staff support; post-incident reviews; and professional responsibility set within a multi-disciplinary framework. The study discussed here indicated that these disparate elements were available and staff were aware of the mechanisms involved, felt supported by colleagues, line managers and the organisation more widely. The increased levels of violence experienced by staff within assessment & treatment settings, in comparison with other clinical areas, was significant. This was further compounded by the role of qualified nurses within these acute areas and it does not seem unfair to suggest that the needs of this group have been given less emphasis than community nurses. A disproportionate number of qualified staff within these areas experienced violence, partly reflecting the nature of the area, particularly the needs of service users during the complexity of relationship building following initial admission. It seems not unlikely, furthermore, that this group were also the ones likely to be more discerning in the extent to which they reported incidents. It seems possible that the application of the concept of zero tolerance to the behaviour of people with a learning disability might be inappropriate or even disingenuous. The relationship

between learning disability nurse and service user is central to our understanding of the issue, many qualified staff, perhaps, experiencing a degree of ambivalence about whether they should report an incident.

Limitations

The study was conducted within one NHS learning disability service and may be difficult to generalise to other areas, particularly the independent sector, though the whole population sample and reasonable response rate compensate to some degree. More opportunity within the data collection instrument for respondents to be more expansive may also have proven fruitful, and self-reported data has its difficulties.

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